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TREATMENT OF DRUG ADDICTION.

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It is not the function of the Public Health Service to pass upon the merits of the various methods of treating narcotic drug addiction, but in view of the recent decisions of the United States Supreme Court, a digest of which has been published in Public Health Reports,[1] it seems desirable that the medical profession should be advised at least to the extent of aiding its members to determine what does and what does not constitute legitimate professional practice. The court having decided that narcotic drugs may not be prescribed or dispensed to an addict except for the purpose of cure, and one of the recognized methods of curative treatment being the reduction method, which consists in tapering off the dosage until the patient is "off the drug," while various other methods involve the maintenance of a certain dosage during a period in which the patient is prepared, by other medication, for abrupt or rapid withdrawal, it is important that physicians should understand to what extent and in what manner the legitimacy of these curative treatments is affected by the recent court rulings.

For this purpose, all methods of curative treatment may be divided into two broad classes—the "ambulatory" and the "institutional." The ambulatory treatment may be defined, for the present purpose, as any treatment in which narcotic drugs are prescribed or dispensed to a patient for self-administration by the patient, so that he has control and possession of the drugs, and is physically free to use them in any manner he desires, regardless of the physician's instructions. The institutional treatment may be defined, for the present purpose, as any treatment in which narcotic drugs, if used at all, are administered by a physician or by a nurse under a physician's direction.

One of the purposes of the Harrison law, as declared by the Supreme Court in the Doremus case, was to prevent the possibility of narcotic drugs being illegally disposed of without payment of the tax and without the use of order forms. Obviously, the use of narcotic drugs under the institutional treatment fully precludes this illegal

[1] Public Health Reports, vol. 34, No. 22, May 30, 1919, pp. 1195-1197.

disposition, while their use under the conditions of the ambulatory treatment, as above defined, clearly facilitates it. The latter form of treatment readily lends itself to abuse by unscrupulous physicians who merely make a pretense of cure, and most of the successful prosecutions of physicians for illegitimate practice under the Harrison law have been in cases where the physician professed to be using the ambulatory reduction treatment for the purpose of cure.

Investigations have been made of the merits of the ambulatory treatment from the medical standpoint, and it is found that genuine cures have rarely been effected by it. Competent authorities, therefore, feel justified in advising against the use of this so-called method of curative treatment. In so far as the question of legitimacy of medical practice in the treatment of drug addiction depends on the presence or absence of professional good faith, the physician using this method must realize that he places himself in the power of his patients, and that his good faith becomes, to a great extent, dependent upon theirs. Reputable physicians can not afford to run this risk, except, possibly, in a few rare and exceptional cases. Among the medical objections to the ambulatory treatment are the facts that hypodermic administration by the patient often leads to serious abscesses through lack of sufficient sterilization; that for the same reason, and through common use of a needle by several patients, syphilis and other communicable diseases are occasionally transmitted; and that this method does not give the physician an opportunity to control the amount administered at each dose and the intervals between doses, and thus determine the minimum physiological requirements of the patient.

In order to avoid misunderstanding, two points require mention. One is that by the phrase "narcotic drugs," as used in the foregoing paragraphs, is meant only opium, coca leaves, or any compound, manufacture, salt, derivative or preparation thereof, since these are the drugs with which the Harrison law deals. The other point is that nothing in the recent court decisions affects the right of physicians to use these drugs in the treatment of disease or pathological conditions other than drug addiction, including the alleviation of pain. If drug addiction becomes necessarily incidental to such treatment, its continuance is legitimate, so long as conditions exist which medically justify it. Addicts may thus be divided into two classes, the legitimate and the illegitimate. As to the former class the rights and duties of physicians are well expressed in an article in the Weekly Bulletin of the New York City Health Department of May 3, 1919, from which we quote the following:

"Every physician must feel free to treat such cases in accordance with his own professional conscience and judgment, and no reputable physician should hesitate to do so. In this, as in all cases with which

a physician has to deal, it is his duty to seek the underlying cause of the patient's condition, and direct his treatment to the elimination of that, wherever practicable, rather than to the alleviation of symptoms; many cases of drug addiction owe their origin to professional carelessness in this respect. But where it is not possible to remove the cause, and where its continuance renders necessary or desirable, in the practitioner's honest judgment, the use of morphine, or other narcotic, he need not fear getting into legal difficulties by continuing its use, even though the patient be an addict. In fact, it is highly desirable that patients of this class be freely treated by reputable physicians, rather than be compelled to rely on questionable sources for the relief to which they are rightfully entitled."

OCCURRENCE OF MALARIA AND ANOPHELINE MOSQUITOES IN NORTHERN CALIFORNIA.

By WILLIAM B. HERMS, Associate Professor of Parasitology, University of California, and Consulting Entomologist of the California State Board of Health.

California has made remarkable strides in the control of malaria during the past 10 years, having reduced the p evalence of this disease by at least 60 per cent. This is not only the result of organized effort here and there in the more highly malarial districts, but is even more largely the result of widespread, intelligent individual action. At this rate we are encouraged to believe that the end of the next 10 years will see this State practically free from malaria, despite the increasing difficulties which are due to the multiplication of irrigation projects.

Although malaria has existed in California for at least 70 years, no systematic and concerted community effort in the control of anopheline mosquitoes was undertaken until the summer of 1910, when an antimalaria-mosquito organization was effected at Penryn, Placer County. From this time on, interest in mosquito abatement has grown apace,[1] and the need of a State-wide malaria-mosquito survey has become more apparent as a basic principle in a program for the control of malaria, the danger of which disease was so forcibly presented in 1909 by Dr. Wm. F. Snow,[2] then secretary of the State board of health.

Many incidental collections of mosquitoes have been made in various parts of California during the past score of years by various workers with no attempt, however, to carry out a serious systematic mosquito survey prior to 1916. The tremendous task involved in carrying out a State-wide mosquito survey is only partly measured by the 153,650 square miles of territory included within the boundaries of California—an area equal to the combined land surface of

[1] Herms, W. B., 1910. Antimosquito Organization in California. California State Board of Health Monthly Bulletin, Nov., 1910, pp. 313-317.

[2] Snow, Wm. F., 1909. Malaria the Minotaur of California. California State Board of Health Monthly Bulletin, Dec., 1909, pp. 109-112.